SEPTEMBER 2004

Insight

For benefits administrators

Benefits at Work 2004: It's a wrap!

The staff of the Employee Insurance Program (EIP) is pleased so many of you have expressed appreciation for the hard work and dedication reflected in planning another successful conference.

- A very special thanks to the benefits administrators who continuously show interest in, and anticipation for, the conference each year.
- Thanks and appreciation also go to the Embassy Suites Hotel for hosting this year's conference.
- Our gratitude to all of the vendors for their participation, door prizes and sponsorship of Benefits at Work 2004. This year's sponsors were:
  - AETNA (Long Term Care)
  - ASI (TRICARE Supplement)
  - CIGNA HealthCare (CIGNA HMO)
  - Colonial Supplemental Insurance Company (enrollment)
  - Companion HealthCare (Companion HMO)
  - Fringe Benefits Management Company (MoneyPlu$)
  - Medco Health Solutions, Inc. (State Health Plan Prescription Drug Program)
  - The Hartford (Basic Life, Optional Life and Dependent Life)
  - Standard Insurance Company (Basic and Supplemental Long Term Disability)

We look forward to seeing and working with each of you in 2005!

2005 rates now available on the Web

The monthly insurance premiums for 2005 are now available online at www.eip.sc.gov. Choose your category, then select "Rates." There you'll find the rates that will go into effect January 1, 2005. Rates for 2004 will remain on the Employee Insurance Program Web site until after the end of the tax season next April.

Optional employer groups

Please be aware that the rates on the Web site are the **base rates**; they are *not* the rates for groups that are experience rated. If you belong to an optional employer that is experience rated, you should have received your 2005 monthly premium list from EIP. If you have not received it, please call Laura Smoak at 803-734-1623. These premiums will remain in effect through 2005.

Inside...

South Carolina Budget and Control Board
Employee Insurance Program
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Columbia, South Carolina 29211

803-734-0678
(Greater Columbia area)
888-260-9430
(toll-free outside Columbia area)
www.eip.sc.gov

NOE now available for annual enrollment

What's new

The Notice of Election (NOE) form for active subscribers has been revised for plan changes in 2005. Use this new form for annual enrollment. To summarize, the new NOE has been expanded and includes spaces for employees to:

- **Enroll in the new SHP Savings Plan.** This space will replace the one for the Economy Plan.
- **Enroll in the Supplemental Long Term Disability (SLTD) plan.** A separate enrollment form for SLTD is no longer needed.
- **Indicate other health insurance coverage.** This will assist with coordination of benefits.
- If the other health insurance coverage is Medicare, an additional **space has been included to indicate the reason for Medicare coverage** (disability, eligible by age, etc.).
- **Include a phone number at work and an e-mail address.**
- **Designate primary or contingent beneficiaries.**

Note that the form is now three pages to accommodate all information. The first two pages are to be completed by the subscriber and the BA. The third page is the instruction page. It includes helpful information for completing the NOE. Be sure to make copies of the completed NOE for your employees and for your files. Send the original to EIP.

NOE is available online; paper forms will be shipped

- A supply of Active NOE forms will be sent to you. Make additional copies as needed. Employees must fill this form out by hand, sign it and submit it to you by October 31.
- The Active NOE is also available online at www.eip.sc.gov. Choose your category, then choose "Forms." The version of the form that is online is interactive. Employees type the information directly into the spaces provided, print the form, sign it and submit it to you by October 31. Those with Internet access are encouraged to use the interactive NOE.
- Revised NOEs for the other subscriber categories—retirees, survivors, etc.—will be available online by October 1. Those without Internet access may call EIP to request a paper form: 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside Columbia area).

Tips for completing NOEs

- Use black ink when completing a printed form.
- Be sure the employee's name, SSN and group number are entered at the top of Page 2, in case the pages become separated.
- Mark only the benefits for which changes are being made.
- Review the NOE for accuracy, required documentation and for your signature and your employee's.

1 A. Administrative Information section

- **TYPE OF CHANGE.** This block has been expanded to include more types of changes you may encounter, including coordination of benefits and enrollment. Note that a checkbox has been added for "Enrollment." During annual enrollment you can check this box instead of writing "AE" at the top of the form.
- **BA USE ONLY.** A block has been added to indicate 20-hour employees, if your employer has opted to allow coverage for employees working as few as 20 hours.
- **HEALTH SAVINGS ACCOUNT (HSA).** A block has been added to indicate whether an employee enrolling in the new Savings Plan, is also enrolling in a HSA.

2 B. Enrollee Information

Spaces have been added for the employee to include a work phone and e-mail address. Encourage employees to complete these fields, if they apply.

3 C. Medicare and other Coverage Information

This section is new. The information will be used to determine eligibility for enrolling in the Savings Plan as well as for coordination of benefits, including prescription drug benefits. Note that if the employee or his dependents had other coverage within 62 days of the effective date of coverage indicated on the NOE, he must attach a certificate of coverage from the previous insurer to offset any pre-existing condition limitations.

- **MEDICARE PART A AND/OR PART B.** Employees should list themselves and other covered dependents who are eligible for Part A or Part B of Medicare. This section should be completed, regardless of the health plan in which the employee is enrolling.
- **OTHER GROUP HEALTH COVERAGE, INCLUDING PHARMACY BENEFITS.** Employees should list their covered dependents who have other group health insurance coverage. This section should be completed, regardless of the health plan in which the employee is enrolling. This information is used for coordination of benefits. This section of the NOE will also be used for updating EIP's records if a dependent has terminated their other coverage. For example, if a dependent child has terminated other group coverage, the employee should complete an NOE, indicating the termination date.

4 D. Coverage Info

SUPPLEMENTAL LONG TERM DISABILITY (SLTD). Employees may refuse or cancel coverage, or select Plan One or Plan Two, as indicated. This election replaces the need for the SLTD Enroll-

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SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM
ACTIVE NOTICE OF ELECTION (NOE)

1 A. ADMINISTRATIVE INFORMATION

CHECK ONE OF THE FOLLOWING:
- ☐ New Hire
- ☐ Transfer
- ☐ Change

TYPE OF CHANGE
- ☐ Enrollment
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Death
- ☐ Other (specify) _____
- ☐ Address
- ☐ Ineligible Dependent
- ☐ Involuntary loss of coverage
- ☐ Gain of other coverage
- ☐ Coordination of Benefits (See C)

Date of Occurrence: _____

SSN Change – Incorrect # _____ (attach copy of card)

Name Change – Prior _____

BA USE ONLY

Effective Date: _____

Group ID #: _____

Group Name: _____

☐ Permanent Part-time Employee (20 hours)

MONEYPLUS

☐ Yes ☐ No

HEALTH SAVINGS ACCOUNT (HSA)

☐ Yes ☐ No
(For use with Savings Plan)

2 B. ENROLLEE INFORMATION

1. Social Security Number	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM DD YYYY
___-___-____					

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

12. Mailing Address	13. Apt.	14. City	15. State	16. ZIP Code	17. County Code	18. Annual Salary	19. Date of Hire MM DD YYYY

3 C. MEDICARE AND OTHER COVERAGE INFORMATION

LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR B OF MEDICARE.

20. NAME	MEDICARE #	ENTITLED DUE TO	EFFECTIVE DATE PART A MM/DD/YYYY	EFFECTIVE DATE PART B MM/DD/YYYY
	___-___-____-___	☐ AGE ☐ DISABILITY ☐ RENAL DISEASE		
	___-___-____-___	☐ AGE ☐ DISABILITY ☐ RENAL DISEASE		

DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER GROUP HEALTH COVERAGE? ☐ **YES** ☐ **NO**
DOES THIS COVERAGE INCLUDE PHARMACY BENEFITS? ☐ **YES** ☐ **NO**

21. NAME	INSURANCE COMPANY	POLICYHOLDER DATE OF BIRTH	EFFECTIVE DATE OF POLICY	TERMINATION DATE (IF APPLICABLE)

IF YOU AND/OR YOUR DEPENDENTS HAVE HAD OTHER COVERAGE WITH ANOTHER CARRIER WITHIN 62 DAYS OF THIS REQUEST, PLEASE ATTACH A COPY OF YOUR CERTIFICATE OF HEALTH COVERAGE (HIPAA). THIS WILL ENSURE PROPER CREDIT FOR ANY PRE-EXISTING CONDITIONS, IF APPLICABLE.

4 D. COVERAGE INFORMATION

22. **HEALTH** (Refuse or select **one** plan and **one** category.)

Plan
- ☐ Refuse
- ☐ Standard
- ☐ Savings (For non-Medicare Employees)
- ☐ TRICARE Supplement (For Non-Medicare Employees with TRICARE)
- ☐ HMO _____ Name

Category
- ☐ Enrollee
- ☐ Enrollee/Spouse
- ☐ Enrollee/Child(ren)
- ☐ Family

23. **DENTAL** (Select One)
- ☐ Refuse
- ☐ Enrollee
- ☐ Enrollee/Spouse
- ☐ Enrollee/Child
- ☐ Family

24. **DENTAL PLUS** (Select One)
- ☐ No (Refuse)
- ☐ Yes

25. **OPTIONAL LIFE** (Refuse or enter coverage level.)
- ☐ Refuse
- ☐ Coverage Level $_____ (Must be in increments of $10,000)

26. **DEPENDENT LIFE – SPOUSE** (Refuse or enter coverage level.)
- ☐ Refuse
- ☐ Coverage Level $_____ (Must be in increments of $10,000)

27. **DEPENDENT LIFE – CHILD(REN)** (Select One)
- ☐ Refuse
- ☐ $10,000

28. **SUPPLEMENTAL LONG TERM DISABILITY** (Select One)
- ☐ Refuse/Cancel
- ☐ Plan One – 90 day benefit waiting period
- ☐ Plan Two – 180 day benefit waiting period

29. **BASIC LIFE/BASIC LTD** Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

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NAME:_____ SSN#:_____ GROUP #:_____

5 E. DEPENDENT INFORMATION

LIST SPOUSE AT ALL TIMES. LIST CHILDREN TO BE COVERED UNDER EITHER HEALTH/DENTAL OR DEPENDENT LIFE PLAN. IF THEY ARE NOT LISTED, THEY WILL NOT BE COVERED. IS YOUR SPOUSE A STATE EMPLOYEE OR EMPLOYED BY A STATE COVERED ENTITY? ☐ Yes ☐ No

ADD (A) OR DELETE (D)	30. DEPENDENT SSN #	LAST NAME	FIRST NAME	SEX M/F	RELATION	DATE OF BIRTH MM DD YYYY	COMPLETE BELOW IF CHILD IS OVER 19
	Spouse						
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

IF FULL-TIME STUDENT WAS CHECKED AND YOU ARE ENROLLING THE DEPENDENT FOR THE FIRST TIME, ATTACH A FULL-TIME CERTIFICATION FROM THE SCHOOL. IF INCAPACITATED WAS CHECKED, ATTACH THE INCAPACITATED CHILD FORM.

6 F. BENEFICIARY INFORMATION – REQUIRED FOR BASIC LIFE AND OPTIONAL LIFE

BASIC LIFE OR OPTIONAL LIFE (Check one or both.)	31. LAST NAME *	FIRST NAME	SSN #	RELATIONSHIP	DATE OF BIRTH MM DD YYYY	PRIMARY OR CONTINGENT
☐ BASIC LIFE ☐ OPTIONAL LIFE						
☐ BASIC LIFE ☐ OPTIONAL LIFE						
☐ BASIC LIFE ☐ OPTIONAL LIFE						

* IF BENEFICIARY IS AN ORGANIZATION OR TRUST, COMPLETE THE FOLLOWING :

ORGANIZATION/TRUST_____

ADDRESS _____

IF TRUST, DATE SIGNED _____

UNLESS OTHERWISE PROVIDED HEREIN, IF TWO OR MORE BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID IN EQUAL SHARES TO THE NAMED SURVIVORS. CONTINGENT BENEFICIARIES HAVE NO RIGHTS UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED.

32. CERTIFICATION: I have read this NOE and made the authorizations herein and have selected the coverage noted. I have provided social security numbers and documentation establishing my dependent's eligibility for the plan(s) selected. **I understand that I may only cancel my coverage and/or my dependent's coverage during an open enrollment period every two years, unless otherwise provided for in the Plan. Should I refuse health coverage or fail to enroll all eligible dependents in health coverage when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period, unless otherwise provided in the Plan. I also understand that I will be able to add or cancel dental coverage only during the open enrollment period every two years unless otherwise provided in the Plan.**

I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary when necessary for enrollment. I hereby authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process all claims for any benefits.

Employee Signature: _____ Date:_____

33. I hereby attest that the employee meets eligibility requirements of plan, proper premiums are being collected, form is complete and accurate, and all required documentation is attached in order to process NOE form.

Benefits Administrator Signature: _____ Date: _____

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

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NOE now available

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ment Form, which will be removed from the EIP Web site January 1.

5 E. Dependent Info

- A single checkbox is located at the start of this section to indicate whether the employee's spouse is also employed by a participating employer.
- **COMPLETE BELOW IF CHILD IS OVER 19.** Employees must indicate whether any listed dependent child older than 19 is a full-time student or incapacitated and attach the appropriate documentation as required, such as a letter of certification from the academic institution or an Incapacitated Child Certification Form.

6 F. Beneficiary Info

- **PRIMARY OR CONTINGENT.** Space has been added for employees to indicate whether their Basic Life and Optional Life Insurance beneficiaries are primary beneficiaries or contingent beneficiaries. Contingent beneficiaries are paid only if any and all primary beneficiaries have predeceased the employee at the time of the employee's death.
- **IF A BENEFICIARY IS AN ORGANIZATION OR TRUST.** Space has been added for naming an organization or trust as beneficiary. Employees must complete the additional information requested on the form.
- **CERTIFICATION AND AUTHORIZATION.** A disclaimer has been added at the end of the form, below the space for the benefits administrator's signature.

Got a question about this form? Need assistance in helping an employee complete it? Call EIP at 803-734-2352 (Greater Columbia area) or 888-260-9430 (toll-free outside Columbia area).

Companion HMO deductible

Some questions have arisen regarding the Companion HealthCare deductible that will go into effect January 1, 2005. To clarify, the deductible does not apply to the following:

- Physician office visits, for both Primary Care Physicians and Specialists
- Pharmacy benefits, both retail and mail order
- Specialty pharmaceuticals
- Routine physicals
- Mammograms
- Well child care and immunizations

The deductible only applies to:

- Professional (physician) services rendered at the hospital. This includes inpatient, outpatient and emergency. It also includes therapies.
- Skilled nursing facilities
- Other services (i.e., durable medical equipment, hospice, home health, etc.)

Copayments do not count toward meeting the deductible. If you have any questions, please contact Companion HealthCare at 800-868-2528.

Clarification of TRICARE Supplement premiums

At the recent Benefits at Work conference, an information sheet on the TRICARE Supplement plan was distributed in one of the workshops. The monthly premiums were not listed accurately on the sheet. The premiums listed on the information sheet should read as follows:

Active employees

	Employer pays	Subscriber pays
Employee only	$63.50	$0
Employee/spouse	$122.50	$0
Employee/children	$122.50	$0
Full family	$163.50	$0

Retirees under age 65

	Employer pays	Subscriber pays
Retiree only	$63.50	$0
Retiree/spouse	$122.50	$0
Retiree/children	$122.50	$0
Full family	$163.50	$0

What is the TRICARE Supplement Plan?

TRICARE is a medical plan offered by the United States Department of Defense, and the TRICARE Supplement plan is a health benefits choice for military TRICARE-eligible employees and their families. As an alternative to the plans offered by the Employee Insurance Program, the TRICARE Supplement plan provides TRICARE beneficiaries additional coverage that typically pays 100 percent of covered expenses. Eligible subscribers who have employer-funded coverage do not pay any premiums for this plan. In addition, TRICARE and the TRICARE Supplement are fully portable—coverage follows the employee if he leaves his current employment.

To learn more about the TRICARE Supplement plan, visit www.scemployee29.absmil.net or call 800-638-2610, ext. 255. You may also attend one of TRICARE's upcoming informational meetings for TRICARE eligible state employees and dependents. For a schedule of these meetings, visit the TRICARE Web site at www.scemployee29.absmil.net/sc29/docs/SC_meetingLocationDates.pdf.

Important MoneyPlu$ enrollment information

MoneyPlu$ enrollment form

With the new MoneyPlu$ Health Savings Account being offered to those who enroll in the State Health Plan (SHP) Savings Plan, significant changes were made to the 2005 MoneyPlu$ enrollment form that you will use during annual enrollment. Here is a brief summary of those changes and some helpful tips for completing the new form.

The form is now legal-size (8 ½" x 14"). The form is available online at www.eip.sc.gov. Choose your category, then select "Forms." You can print the online version on letter-size paper (8 ½" x 11"), but it will appear smaller than it would on legal-size.

The form covers four MoneyPlu$ features:

- **Section A—Health Savings Account (HSA)**. Eligible employees who sign up for this feature will receive additional information from NBSC, the HSA trustee, after annual enrollment.
- **Section B—*Limited-use* Medical Spending Account**. This is available only to eligible employees who sign up for the HSA in Section A of the enrollment form. Employees can only use this account to pay expenses that are NOT covered under the SHP Savings Plan, such as dental care and vision care expenses.
- **Section C—Medical Spending Account.** This is the *full* MSA and is available to any eligible employees who do NOT sign up for the HSA.
- **Section D—Dependent Care Account.** This is available to all eligible employees.

General tips for completing the enrollment form

- Advise your employees to read carefully the important information on the back of the form.
- Please be sure to review the sections completed by your employees to ensure:
  - Those enrolling in the HSA are also enrolling in the SHP Savings Plan
  - Those enrolling in the HSA *and* a Medical Spending Account (MSA) are enrolling in the *limited-use* MSA (Section B), and not the *full* MSA (Section C)
  - The number of paychecks and per-pay-period deductions are correct for each feature in which they enroll. If planning to retire or leave employment during the year, they should check the box, just above the signature line, and indicate how many pay checks they plan to receive before the date of termination.
  - They have signed and dated the form where indicated (near the bottom)
- Be sure to complete the benefits administrator section and fill in all required information:
  - Sign and date the form.
  - Indicate if the form is for a quarterly change to an HSA account. (This will not apply during annual enrollment, but will apply during 2005 as HSA partici pants may change or cancel their elections on a quarterly basis.)
  - Include your payroll center, payroll frequency and group number.
- Send completed enrollment forms directly to FBMC. Do NOT send them to EIP. The deadline for sending enrollment forms to FBMC for annual enrollment is November 15.

Tips for completing Section A (HSA)

- Advise your employees to read carefully the six-page, HSA custodial disclosure information. This information should be distributed along with the form. If accessing the enrollment form online, this information is part of the enrollment form file.
- **Select which type of SHP Savings Plan coverage.** Employees must check the box indicating whether they are enrolling as an individual (subscriber-only coverage) or as a family (subscriber/spouse, subscriber/children or full family coverage).

- **Identification Information**. Anyone enrolling in an HSA *must* provide identification as required by federal law (USA Patriot Act). Acceptable forms of ID are included in the instructions.
- **Designation of Beneficiary**. Employees enrolling in the HSA may designate primary and contingent beneficiaries for their HSA assets. If no percentages are listed, each beneficiary will share equally. Social Security or Taxpayer ID numbers must be included as well as relationship and date of birth.
- **Spousal Consent**. Employees enrolling the HSA must indicate whether they are married. If they are married and they designate a beneficiary *other* than their spouse, the spouse must sign the form where indicated to acknowledge consent to the beneficiary designation. A witness must also sign, verifying the spouse's signature.

If you have any questions about the new enrollment form, contact Fringe Benefits Management Company (FBMC) at 800-872-0345.

Health Savings Account custodial agreement/disclosure statement

As part of the HSA enrollment materials, you should receive a six-page custodial account agreement and disclosure statement. This was developed by NBSC, an affiliate of Synovus. NBSC will serve as the custodian for the HSAs. A list of NBSC branches in South Carolina is available at www.eip.sc.gov. To access the list, just choose your category and select "Online Directories."

This information is very important and must be provided to anyone who is considering enrolling in the MoneyPlu$

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HSA. It explains such information such as:

- What happens to an HSA account if the accountholder dies, including tax treatment of the funds
- Allowable HSA investments and delegating investment authority
- Transfer and rollover contributions—What may and may not be transferred to an HSA
- The right to revoke an HSA
- Tax consequences for prohibited transactions from an HSA
- End-of-year tax forms and annual statements
- Contribution limits for one or more HSAs and employer contribution information, including withholding
- Availability of funds

If you have any questions regarding the custodial agreement/disclosure statement, call FBMC at 800-872-0345.

After enrollment

Following enrollment, FBMC will forward to NBSC information and data from the enrollment forms of those employees who enroll in the MoneyPlu$ HSA. NBSC will then send those enrollees additional information and forms to complete to set up their HSAs.

Prior to January 1, 2005, NBSC will send HSA Visa check cards out to accountholders. Those with single coverage under the SHP Savings Plan will receive one card; those with family coverage will receive two. A starter supply of checks will also be sent along with other important account information.

If an employee enrolls in the SHP Savings Plan

Employees enrolling in the SHP Savings Plan may choose to:

- **Enroll in an HSA**, with or without also enrolling in a *limited-use* MSA (Section B of the enrollment form); OR
- **Enroll in a *full* MSA** (section C of the enrollment form), but *not* the HSA or limited-use MSA. A full MSA is considered "other health insurance" by the IRS, therefore full MSA participants are ineligible to contribute to HSAs.

Be aware that any Savings Plan enrollees who enroll in the *full* MSA cannot change their election in a later quarter to contribute to an HSA, until:

- The next annual or open enrollment, when they can drop their MSA for the following year and enroll in the HSA instead; OR
- They have a change in status event that allows them to terminate their full MSA. Keep in mind that not all changes in status allow participants to terminate their MSA accounts; a change to an MSA must be consistent with the change in status event.

If an *employer* wishes to contribute to HSAs

Any employers that are considering contributing to HSAs on behalf of participants should keep the following in mind:

- Once the contributions are made, the money belongs to the employees. The employee is responsible for ensuring the funds are used for qualified medical expenses out of their HSAs, just like employee contributions. When employees leave employment, they take the money with them.
- Employer contributions are made on an after-tax basis and cannot be made through MoneyPlu$. Employer contributions to an employee's HSA are tax-free; they are treated as employer-provided coverage for medical expenses under a health plan and are excludable from the employee's gross income. Employer contributions are not subject to withholding from wages for income tax or subject

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2004 Annual enrollment materials

Below is an update on enrollment materials coming your way. Refer to your October 2004 issue of *The BA Advantage* for the original article and additional information.

MoneyPlu$

(Fringe Benefits Management Co.) (800-872-0345)

There have been some changes to the enrollment information you will be receiving regarding the MoneyPlu$ program. Around October 1, you should receive:

- **Marketing flyers**, highlighting the new MoneyPlu$ Health Savings Account (HSA), to distribute to all employees.
- **Enrollment forms**. The MoneyPlu$ enrollment form has changed significantly and now includes four sections for completion. Refer to the article on page 6 for more information on the new enrollment form.
- Section A—The new MoneyPlu$ HSA, available to employees who enroll in the new State Health Plan Savings Plan. Employees who sign up for this feature will receive additional information from NBSC, the HSA trustee, after annual enrollment.
- Section B—A limited Medical Spending Account, available only to eligible employees who sign up for the HSA in Section A on the enrollment form
- Section C—Medical Spending Account, available to any eligible employees who do NOT sign up for the HSA
- Section D—Dependent Care Account, available to all eligible employees.

  Be sure to complete the benefits administrator section near the bottom of the form!
- **A supply of the new MoneyPlu$ enrollment booklets**. Due to significant changes to the MoneyPlu$ program, this booklet will not be available by October 1, but will be sent to you soon afterward. This booklet explains all of the features, including the new HSA and the new Medical Spending Account debit card. Please distribute to those employees who sign up for any of the MoneyPlu$ programs or who are seeking additional information before making a decision.
- The general informational tri-fold brochure on the MoneyPlu$ Program, that was available in the past, has been discontinued.

Flyers and forms are available on the EIP Web site at www.eip.sc.gov. The enrollment book will be posted on the EIP Web site when it is completed.

South Carolina Budget and Control Board
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MoneyPlu$ enrollment information

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to FICA, federal unemployment tax, or the Railroad Retirement Act.

- Employer contributions are reported at the end of the year on employees' W-2 forms, in the space designated for HSA contributions. Employees may then deduct those employer contributions on their tax returns.
- Employers must contribute for all *SHP Savings Plan participants who are eligible for an HSA*. It is the employee's responsibility to establish and open an HSA account, either through MoneyPlu$ or elsewhere.
- Employers must contribute the same amount for each participant. For example, an employer cannot contribute $600 for one participant and $1,000 for another.
- Employer contributions count toward the maximum annual allowable contribution—$2,600 for single coverage and $5,150 for family coverage for 2004—and reduces the amount those employees can contribute for that year. For example, if the employer contributes $600 to each HSA, those employees can only contribute $2,000 or $4,550.

For additional information regarding employer contributions to HSAs, consult a tax advisor. You may find the following Web sites helpful as well: www.irs.gov and www.hsainsider.com.

Insight

is produced monthly by the South Carolina Budget and Control Board Employee Insurance Program